McLaren Medical Group

Chronic Pain Progress Note

Date

Reason for Visit

Chief Complaint

Diagnosis requiring pain management

_____

Have you run a MAPS for this patient? ☐ Yes ☐ No

Is there a pain management contract signed within the past 6 months? ☐ Yes ☐ No

If there is not a pain management contract, or there is one greater than 6 months old, has this been updated? ☐ Yes ☐ No

Functional Levels

1. Has pain increased over the past week? ☐ No ☐Yes

2. Is patient limited in their activities of daily living? ☐ No ☐ Yes

If yes, what activities of daily living are limited?

☐ Standing ☐ Sitting ☐ Walking

☐ Up or down stairs ☐ Getting dressed ☐ Bending over

☐ Other:_____

3. Use the following scale to indicate the patient's current functional level **at home**: (circle one)

0 = pain free to worst pain ever = 10

0 1 2 3 4 5 6 7 8 9 10

What was the patient's functional level **at home** the first time you treated them for pain? (put number here) _____

Has there been an improvement? ☐ Yes ☐ No

_____

Does the patient work? ☐ Yes ☐ No
If yes, continue to #4

4. Use the following scale to indicate the patient's current functional level at work: (circle one)

0 = pain free to worst pain ever = 10

0 1 2 3 4 5 6 7 8 9 10

What was the patient's functional level **at work** the first time you treated them for pain? (put number here) _____

Has there been an improvement? ☐ Yes ☐ No

Has the patient had any of the following changes in daily activities or habits?
☐ Insomnia ☐ Loss of appetite/weight loss
☐ Incontinence ☐ Changes in mood/emotions (anger, crying, etc.)
☐ Exercise_____

☐ Other:_____

Medications
List current medications

Pain Rating
Use the following scale to have the patient rate their pain today: (circle one)

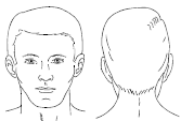
0 = pain free to worst pain ever = 10

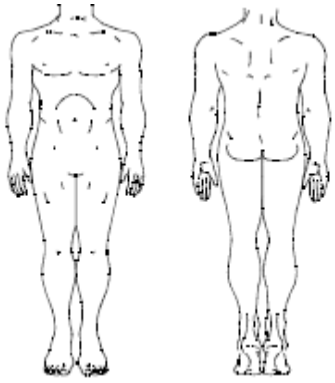
0 1 2 3 4 5 6 7 8 9 10

What was their pain rating at last visit? (Put number here) _____

Has there been an improvement? ☐ Yes ☐ No

Location





Vitals: BP: T: P: R:

Ht: Wt: BMI:

Nurse/MA Signature:_____

PATIENT NAME:

DATE OF BIRTH:

ROS

CONST
Fever_____
Subjective / to _____◦F/◦C
Chills_____
Fatigue_____

SKIN/MS
rash_____
back pain_____
leg pain_____
foot swelling_____

ENT
Sore throat_____
Nasal drainage/
Congestion_____

Pulmonary/CVS
cough_____
sputum_____
trouble breathing_____
chest pain_____

NEURO/EYES
Headache_____
Blackout_____
Lost feeling/power_____
Arm leg face R/L

GI
abdominal pain_____
nausea/vomiting_____
diarrhea_____
black/bloody stools_____
difficulty walking_____
difficulty with speech_____
double vision_____
confusion_____

GU
Problems urinating_____
Frequent urination_____

PHYSICAL EXAM

General Appearance
___no acute distress
___ alert
___mild / moderate / severe distress_____
___ anxious / lethargic_____

ENT
___normal ENT inspection
___normal pharynx
___normal inspection
___normal thyroid
___scleral icterus / pale conjunctivae_____
___purulent nasal drainage_____
___pharyngeal erythema / exudates_____
___thyromegaly_____
___lymphadenopahy (R / L)_____
___ JVD present_____
___carotid bruits_____

RESPIRATORY
___no resp. distress
___normal breath sounds
___chest non-tender
___see diagram (on previous page) _____
___wheezing_____
___rales / rhonchi_____

CVS
___reg. rate & rhythm
___no murmur
___no gallop
___irregularly irregular rhythm_____
___murmur grade___/6 sys / dias
___ gallop (S3 / S4)
___extrasystoles_____
___tachycardia_____
___friction rub_____

ABDOMEN
___soft, non-tender
___no organomegaly
___normal bowel sounds
___tenderness_____
___guarding / rebound_____
___abnormal bowel sounds / bruits_____

BACK
___normal inspection
___CVA tenderness (R / L)
___discoloration

EXTREMITIES
___non-tender
___no pedal edema
___normal pulses
___calf tenderness_____
___varicose veins_____
___pedal edema_____
___decreased pulse(s)_____
___discoloration_____

NEURO / PSYCH
___oriented x3
___CNS normal as tested
___no motor / snsry deficit
___normal reflexes
___normal mood / affect
___disoriented_____
to: person / place / time
___ facial droop / EOM palsy_____
___weakness / sensory loss_____
___derpressed mood / affect_____

PAST HX ___negative _____
_____

ALLERGIES ___NKA _____

SOCIAL HX smoker_____ppd ETOH/drug use_____
FAMILY HX _____

Has patient ever participated in a pain management clinic? ☐ Yes ☐ No

If yes, when and what was the result? _____
_____

Has the patient's pain rating improved since the onset of treatment for pain? ☐ Yes ☐ No

Has the patient's functional status improved since the onset of treatment for pain? ☐ Yes ☐ No

Labs/Tests Ordered

_____

_____

_____

Clinical Impression

_____

_____

TREATMENT PLAN TO IMPROVE PATIENT FUNCTION
Outline the treatment plan to improve the patient's pain rating and functional capacity. Specifically list goals (based on patient's current functional capacity) that will assist with determining when pain management is being successful. If patient is working, define when they can return to work and any work limitations. Give specific timelines.

☐ Schedule a consultation with Dr. _____

Date of consult_____

Total Time _____min. > 50% counseling ____yes ____no

Physician Signature **Date**

PATIENT NAME:

DATE OF BIRTH: